

**EVERY WOMAN MATTERS****Provider Training Outcomes** (to be completed by Case Manager)

Copy this page and send to Quality Assurance Coordinator Quarterly

Clinic Name _____ Region _____

Date of Training _____ Onsite _____ Phone _____

Implementation of	Clinic Staff verbalizes understanding at time of training	Clinic Staff Needs further training/information*	Not applicable	Comments
1. Treatment Process				
2. Cervical follow up & treatment plan				
3. Breast Followup & treatment plan				
4. Cardiovascular Followup & treatment Plan				
5. CVD intervention forms & process				
6. Women deemed Lost to followup form				
7. Client informed refusal form				
	Clinic Staff Demonstrates knowledge	Clinic Staff Needs further training/information*	Not applicable	Comments
8. Straight Talk about Breast Cancer/Spanish treatment booklet				
9. Every Provider Matters Newsletter				
10. Colorectal Cancer Pilot Project				
11. Current Professional Education Information				
13. EWM Promotional Materials				

Comments _____

* See Page 3 for Follow up training plans--to be completed with all training sessions
PROV/CME/1-2004 rev.3/2005

Provider Training Sign In Sheet

Clinic Name _____

Date of Training _____

#	Name	Position/Title
1.		
2.		
3.		
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19.		

Provider Training Follow Up

To be completed with all training sessions

Section A To be completed at initial training session

Provider/clinic name _____ Contact person _____

Date of initial training session _____

_____ onsite _____ phone _____ email

Scheduled date of follow up training session _____

Issues to be addressed at follow up session

_____ Forms (list) _____

_____ Other (list) _____

Section B To be completed at Follow up training session

Date of session _____

_____ onsite _____ phone _____ email

Issues addressed (list) Response by staff

Comments _____

Further follow up plan

Scheduled date for follow up _____

_____ onsite _____ phone _____ email

Section C To be completed if no follow up is scheduled

Future follow up to be initiated by

_____ clinic staff (name) _____

_____ case manager tentative date _____

Provider Training Sign In Sheet For Follow up Session

Clinic Name _____

Date of Training _____

#	Name	Position/Title
20.		
21.		
22.		
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